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ABSTRACT

The paper briefly discusses 12 critical issues that significantly affect program success in reducing severe self-injurious behavior (SIB) in group homes. The paper emphasizes the necessity of: (1) a process approach to the development and monitoring of treatment; (2) demythologizing the self-injurious client; (3) discussing and clarifying legal liability issues early and often in treatment; (4) attending to staff stress tolerance levels; (5) attending to other clients' stress tolerance levels; (6) facilitating and developing staff support systems and lines of communication; (7) recognizing and addressing the staff's emotional response to the treatment; (8) minimizing or eliminating pressure from non-team members who question the program; (9) maximizing staff self-direction and decision-making ability in a crisis situation; (10) developing the staff's understanding of the probable course of treatment; (11) anticipating the effects on other clients' programs; and (12) accepting that there may be differential program effects. The paper concludes that the success of a program to reduce self-injurious behavior has less to do with behavior technology available than with the confluence of staff, client, and communication/support issues. (LH)

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Critical Issues in the Treatment of Severe Self-Injurious Behavior in the Group Home Setting

Self-injurious behavior (SIB) is a frequent and disconcerting problem facing professionals, paraprofessionals, and parents working with the mentally retarded.

Despite increased attention by researchers in recent years and the resultant innovative behavioral technological advances intreating SIB, success in the group home setting has been problematic.

The group home setting, in addition to falling prey to the usual treatment issues discussed by researchers in the literature (e.g., program complexity, validity, and reliability, documentation), also faces numerous other critical issues which affect the success or failure of a treatment approach.

The literature on the treatment of SIB addresses only indirectly the effects that the people who implement the treatment program have on the success of the program. There is an assumption inherent in the literature on SIB that once a client is assessed and a treatment plan developed that implementation of that plan and data collection are "givens." However, in my work with numerous group homes and self-injurious clients several issues continually resurface which are almost independent of the technique used but have significant effects on program success.

Those critical issues are the following:

1. A process approach to the development and monitoring of the treatment is almost always necessary. Although written accounts of program development and implementation seems fluid and coherent, the reality is that it is frequently a trial and error, start and stop process. A content approach to SIB in the group home dooms it to fail in almost all cases.

2. "Demythologizing" the SIB client. Clients who exhibit SIB over a number of placements, staff, and time tend to be mythologized by staff. Stories about severe injuries, excessive exhibitions of SIB, heroic interventions and the like accrete around the client and are resistive to change. Such myths many times reduce the effects of even the best conceived program.

3. Addressing legal liability issues. Direct service staff often have deep concerns over whether or not they are legally responsible for injuries sustained during a restraint or extinction procedure. These concerns need to be discussed and clarified early and often in the treatment process.

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4. Attending to staff stress tolerance levels. An intensive SIB program is stressful on everyone. The need for stress management, respite time, schedule modifications, support from other staff, and reinforcement from supervisors should be open for discussion during the program implementation phase.

5. Attending to other clients' stress tolerance levels. Other clients can and do react strongly to both the SIB and its treatment. Physical acting out, yelling, self-injurious behavior, and physical and emotional withdrawl are common responses. Staff having to deal with such responses frequently mitigates against proper implementation of the SIB program.

6. Facilitating and developing staff support systems and lines of communication. Amost all programs, and particularly those for SIB, require that staff work in concert, support each other, and minimize gaps in communication. A process approach encourages this. Lack of attention to staff supports and communication leads to inconsistency and ultimately to the failure of the program.

7. Recognizing and addressing staff's emotional response to the treatment. Direct service staff, particularly, express powerful emotional responses to both the SIB and to the treatment procedures. Frustration, anger, disappointment, and elation need to be processed by staff for two reasons; their response is a component of their psychological working conditions and, their response is a potentially strong reinforcer of the SIB client's behavior.

8. Minimizing or eliminating pressures from non-team members who question the program. In a group home setting especially, there are numerous opportunities for those not directly involved in SIB program implementaiton to give unsolicited input. This input can have varying effects on staff - almost always negative. Input from outside sources should be anticipated and open for discussion when it does occur.

9. Maximizing staff self-direction and decision-making ability in a crisis situation. Especially for those staff working the overnight, weekend, or holiday shifts, program consistency depends on the commitment, knowledge of the program, and some sort of "crisis management sequence" being clear from the start.

10. Developing staff's understanding of the probable course of the treatment. It greatly reduces staff anxiety to discuss beforehand what might occur as the result of the intervention. For example, staff should know a priori that increases in SIB are likely to occur initially under extinction conditions but that usually rates will decrease drastically after that. Staff who are unaware of that get discouraged and fail to continue to carry out the program procedures.

11. Anticipating the effects on other clients' programs. There may be both positive and negative effects on other clients' programs as the result of an intensive SIB program. A high density reinforcement program, for example, may induce acting out by other clients as they attempt to "get their share" of the reinforcers. On the positive side, it often happens that when staff learn how to reinforce creatively or extinguish inappropriate behaviors well, they feel more competent and begin to generalize those new learnings to other client programs.

12. Accepting that there may be differential program effects. Staff sometimes become frustrated when a program is successful in some situations but not in others. They will discount the effectiveness of the program as a whole and discontinue implementation. Again, ongoing processing and communication among staff reduces the chance that a program will fail in these cases.

To summarize, my experience has been that in the group home setting the success of a program to reduce severe self-injurious behavior has less to do with the behavioral technology available than with the confluence of staff, client, and communication/support issues.

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